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We must resuscitate the system in order to expand coverage, lower cost

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In 2004, the U.S. spent 16 percent of its GDP on health care — the most of any nation — while Germany came in a distant second at less than 11 percent. We spent $6,102 per capita on healthcare, more than twice as much as the $2,571 median for developed (OECD) countries. We also spend the highest percentage of the healthcare dollar on administration — more than two and a half times that of the OECD median.

Despite this level of investment, the U.S. has the highest percentage of its population uninsured and patients here are nearly twice as likely to die from surgical or medical mishaps. In 2002, the U.S. had the highest infant mortality level of 20 industrialized nations. These are not blue ribbons to be proud of. These statistics point up the urgent need for changes in our medical delivery and payment system.

The U.S. has public and private insurance programs, both for-profit and not-for-profit. Each program, regardless of who sponsors it, has three basic common elements: a set of defined benefits, a payment structure to reimburse providers, and a financing mechanism of premiums, cost-sharing and taxes paid by the beneficiaries, employers and the general public.

Each program uses free-market bargaining and is subject to government or institutional regulations and price setting. The Centers for Medicare and Medicaid Services (which runs Medicare and Medicaid), state governments, the Department of Defense, unions, private employers and insurance companies all set or negotiate rates and benefits.

Individuals, without the technical knowledge needed for sound medical decision-making, could never bargain as effectively as these large buyers. Shifting more cost and responsibility to the consumer as a strategy for reform or cost-containment is useless.

More than 47 million people are uninsured, and even more have substandard coverage that won’t protect them when illness arises. Recent surveys indicate that a majority of Americans share a strong hope that the next occupant of the White House will work with the Congress to address this issue. As we have learned from past attempts, the best-laid plans of any one party, interest group, or industry are insufficient to achieve the goal. Success will require negotiation and compromise from everyone. Our private profit, non-profit and public programs must work in harmony to bring about

needed change.

I’ve introduced the AmeriCare Health Care Act (H.R. 1841), which allows those who are happy with their current coverage to keep it, and ensures affordable private and public options for everyone, including a buy-in to a revised Medicare program.

AmeriCare is financed by through individual, employer, and federal contributions, with extra help for those in need. According to the independent Commonwealth Fund, by focusing on prevention, lowering administrative costs, and covering everyone, AmeriCare could reduce overall health spending by more than $60 billion in its first year, and save the average family $1,500.

The plan is endorsed by: AFL-CIO, American Academy of Pediatrics, American Nurses Association, Center for Medicare Advocacy, Consumers Union, FamiliesUSA, National Association of Community Health Centers, National Association of Public Hospitals, SEIU and others.

We should not wait until next year to start building the base for reform. Adoption of electronic medical records and a comparative effectiveness research program can give us the data needed to improve healthcare outcomes and reduce costs. These improvements are a vital component of reform, and can be put to good use in today’s system as well.

Standardized health information is key to cost-containment and quality improvement. The technology is there. The most efficient and effective way to quickly achieve adoption and ensure compliance would be to have the federal government require providers to use one system, help pay for it and supervise the confidential collection and utilization of all medical records and outcome data.

Used properly, health IT can substantially reduce spending for duplicative tests and other wasteful activities. More importantly, it can provide the base for a new, robust comparative effectiveness research program. The goal of this research should be to give doctors and patients reliable and unbiased information about which treatments result in the best outcomes. Funding should be broad-based and automatic, with contributions from Medicare and private payers.

A collaborative public-private effort is the best way to build trust among clinicians, patients and the public, and to ensure independence and accountability. Last year’s House-passed CHAMP Act proposed this kind of program at a cost of just $2 per person annually. CBO even scored savings for this investment. This type of research is routinely done in other countries; it’s time to put our resources to work so that we are assured first-class healthcare with first-class outcomes.

Reform must provide the right of all Americans to quality medical care; the right of every provider to reasonable (not necessarily desired) compensation; and the duty of each person to finance this program according to his or her ability to pay.

Stark is chairman of the Health Subcommittee on the Ways and Means Committee